Bureau of Health Care Quality and Compliance

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/O		, ,	LE CONSTRUCTION	(X3) DATE S COMPLE	
				A. BUILDING B. WING			
		NVS5282PCA				08/	27/2010
NAME OF PR	OVIDER OR SUPPLIER			RESS, CITY, STA			
CARE 4 LI	FE			HARA AVE #1 S, NV 89117	90		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
P 000	0 Initial Comments		P 000				
	a result of the State I in your agency on 08 licensure survey was by authority of NRS 0 Agencies. This findings and corby the Health Division	eficiencies was generate Licensure survey condu /24/10 - 8/27/10. The s conducted at your age Chapter 449, Personal (Inclusions of any investion In shall not be construct	cted state ncy Care gation d as				
	prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The patient census was 40. Ten client records were reviewed. Six client contacts were made. Two home visits were conducted. Ten employee files were reviewed.						
	The following regulat identified:	ory deficiencies were					
P 050	Section 14.1(a-e) Ad	ministrator Qualification	ıs	P 050			
	(a) Be at least 18 year (b) Have a high scho (c) Be responsible ar personal qualities who understand the problems with disabilit (d) Understand the pochapter 449 of NRS;	ol diploma or its equiva and mature and have the lich will enable him to ems of elderly persons ies; rovisions of this chapter and ability to read, write, spe	lent; and				
	This STANDARD is	not met as evidenced b	y:				

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/O		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE S COMPLE	
		NVS5282PCA		B. WING		08/	27/2010
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE	1 00/	2772010
CADE A LIFE				.HARA AVE #1 S, NV 89117	90		
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P 050	Continued From page	e 1		P 050			
	interview, the agency a high school diploma Administrator and the 1. Employee #1 and E	e of a High School Diplos.	ce of e e.				
P 080	Section 14.1(4) Admit Abuse/Neglect	nistrator Responsibility		P 080			
	that: (a) The clients of the neglected or exploited another member of the any person who is visuattendant or another agency is present; and (b) Suspected cases	ne staff of the agency, on siting the client when an member of the staff of the do of abuse, neglect or the marker tare reported in the marker tare reported tare re	, or by i he				
	Based on record revie Administrative Design report a suspected carequired under NRS 2 1. Client file # 1 revea report of alleged abus #5.	aled a documented e-m se of Client# 1 by Emplo ne Administrative Desig	ne o s ail oyee				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/G		(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		IDENTIFICATION NOMB	LIX.	A. BUILDING			
		NVS5282PCA		B. WING		08/27/2010	
NAME OF PR	OVIDER OR SUPPLIER	•	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	'	
CARE 4 L	FE			HARA AVE #1 S, NV 89117	90		
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P 080	the Department of He police department or she office for protective stelephone service designated Department. Scope: 1 Severity	Aging Services Division ealth and Human Serviceriff's office; the county's ervices; or a toll freed by the Aging Services	ces; a	P 080			
P 170		entation of the needs of ersonal care services	f	P 170			
	Based on record revi agency failed to have reflected care provide	ed by staff according to e plans for 10 of 10 clier	the the				
	Notes, used for verifi did not include Medic	he agency's Daily Progreation of services provide cation Reminders as one d for as indicated by the	ded, e of				
	Scope: 3 Severity:	2					
P 230	Section 16.1(a-i) Per	sonnel File		P 230			
	kept for each attenda must include, without						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		NVS5282PCA		B. WING		08/27	7/2010
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE	•	
CARE 4 L	IFE			HARA AVE #1 S, NV 89117	190		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FU .SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
P 230	tests or obtained the oby NAC 441A.375; (d) Evidence that the attendant were check (e) Evidence of compthe administrator of the person licensed to oprespect to the attendart (f) Proof that, within 6 began working for the attendant obtained a cardiopulmonary result American National Recertificate approved b (g) Proof that the attendart obtained and certificate approved b (g) Proof of possessic least the minimum lial coverage required by will be providing transmotor vehicle; and (i) Documentation of a performance evaluation attendant.	a the attendant began y; at the attendant has had certificates required references supplied by ed by the agency; liance with NRS 449.17 are agency or the erate the agency with unt; months after the attendaction issued by the ed Cross or an equivale y the Health Division; andant is at least 18 years on by the attendant of a billity insurance state law if the attendaction to a client in a fall training attended by ons of the	the 79 by dant d ent ars of at ant a	P 230			
	Based on policy revie interview, the agency employee file for 5 of	not met as evidenced b w, record review and si failed to provide a com 10 employees. ot have an employee file	taff iplete				
	2. Employees #1 and documentation of an a	#2 were missing address and telephone					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBI		(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE SURVE COMPLETED	ξY
		NVS5282PCA		B. WING		08/27/2	010
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
CARE 4 L	FE			HARA AVE #1 S, NV 89117	90		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
P 230	Continued From page	e 4		P 230			
		e, current documentation to the physical examination to the					
	3. Employee #3 and # documented evidence	#7's personnel files lack e of reference checks.	ked				
	that individuals who jo qualified and have a s productive and succe	#203 states, "To ensur bin Care 4 Life are well strong potential to be ssful, it is the policy of apployment references of	Care				
	Two of the five of the supplied by the employ Review of documenta #4 files and interviews Designee and the HR evidence that Employ of complaints register Review of the Employ revealed that Employ	ployment reference che personal references byee were checked. Ition of Client #1 and C is with the Administrative Manager revealed free #6 had been the sured with the agency. If yee Corrective Action Free #6 was terminated come of the client compla	lient e bject orm				
	Scope: 2 Severity: 2	2					
P 280	Section 17/1(2) Document	mentation of Supervision	on	P 280			
	must be documented. documentation must be administrator or his de supervisory visit and e consist of an evaluation	oe dated and signed by esignee. Each each telephone call mu on of whether: afe techniques have be	the st				

		(X1) PROVIDER/SUPPLIER/C			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		NVS5282PCA		B. WING		08/2	7/2010
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	SS, CITY, STA	TE, ZIP CODE		
CARE 4 L	FE		8687 W SAHA LAS VEGAS,		90		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDER OF THE APPROFIDER OF THE APPROFICIENCY)	D BE	(X5) COMPLETE DATE
P 280	been followed; (c) The service plan e meeting the personal client; (d) The attendant proservices to the client of training relating to the the attendant is provide. It is necessary for designee to follow up client concerning any care services being proservice plan establish identified as the result telephone call. This STANDARD is represented to have supervisory home visit of ten clients (Client #	established for the clien care needs of the viding personal care has received sufficient a personal care services ding to the client; and the administrator or his with the attendant or problems in the persor rovided to the client or led for the client that and to fithe supervisory visit documented evidence its or telephone calls for the supervisory visits of the supervisory visit	t has t is t that t is that the the the tror	P 280			
	agency failed to have	ew and staff interview, to documented evidence its or telephone calls fo #2).	of				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBI		(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PF	ROVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	ATE, ZIP CODE	
CARE 4 L	IFE		8687 W SAH LAS VEGAS	HARA AVE #1 5, NV 89117	190	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE
P 280	Continued From page	e 6		P 280		
	March 11, 2009. Rev revealed a lack of documented home telephone calls since confirmed by	e visits or supervisory admission. This was the Administrative Desi	gnee.			
P 510	Section 23.1 Prohibite	ed Services		P 510		
	ensure that each atter the agency is working and conducts himself manner. An attendant any of the services list a client. 2. The services an atta a client include, without (a) Insertion or irrigation (b) Irrigation of any bound insertion of an enema (c) Application of a dramedication or aseptic including, without limit moderate or severe could administration of it muscles or the skin; (e) Administration of rowithout limitation, the suppositories, the approximation of the suppositories, the approximation of the suppositories and the suppositories are supposited to the suppositories and the suppositories are supposited to the supposite suppo	within his scope of ser in a professional is prohibited from provided in subsection 2 to endant must not provide ut limitation: on of a catheter; ody cavity, including, with ear, or a vaginal douche; essing involving prescritechniques, tation, the treatment of onditions of the skin; njections of fluids into variety in or a prescribed kin and the administration al assessments; gns; feeding techniques;	rvice viding de to ithout iption veins,			

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(X4) ID PREFIX TAG			l l	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
P 510	range of motion of a complete (m) Providing medical including, without limit client to the office of a medical information to the client or to receive the physician concern (n) Any task identified the regulations adopted Board of Nursing as recare, including, without that are within the score	ed services to increase client; I case management, tation, accompanying a physician to provide the physician concerne medical information from the client; and in chapter 632 of NRS ed by the State requiring skilled nursing ut limitation, any service pe and practice of a	a ning rom S and	P 510			
	Based on record revie agency failed to preve from performing prohiten clients (Client #2, 1. Review of Client # documentation of a letthe HR Manager. The physical examination client to on 4-28-10. instructions received during the visit. The letter was accomnarrative entitled, "Cadocument refers to the instructions for application date on No evidence was four	not met as evidenced bew and staff interview, the ent personal care attentibited services for three ibited from Employee #1 is eletter referred to an authat the employee took. The letter referred to from the client's doctor in panied by a seven pagaring For Mary". The e act of applying, ation and the recording	the dants e of 1 to nnual a the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB			(X2) MULTIP	LE CONSTRUCTION	(X3) DATE S COMPL		
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NAME OF PE	ROVIDER OR SUPPLIER		STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
CARE 4 L	IFE			NHARA AVE #1 NS, NV 89117	90		
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P 510	Continued From page	e 8		P 510			
	ensure that the caregivers for Client # 2 were not providing prohibited services.		e not				
	a telephone Supervis call from Employee # 12-18-09. The cared given cough syrup to hour coughing spell. the client's coughing swallowing a pill. Caregiver was couns taking the report, to cor margarine prior to HR Manager also left #13 about using the client's pills. The doct Administrator was infinited.	eled by the HR Manage oat client's pills with bu client swallowing them. a message with Emplo outter or margarine on t ument revealed that the	ts a on had a two d that er tter The byee he				
	administered medicated HR Manager had give	vare that the caregiver hat tion to the client or that en instructions for client's medications to					
	home for the purpose activities, information communications betw (Policy T-08 Employe entries by the caregiv following prohibited s Massaging the feet of stroke and providing	veen caregivers and far re Handbook) revealed ver of performing the	iver's mily. ry of a the				

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NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
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P 510	Continued From page	e 9		P 510			
	Scope: 2 Severity: 2						